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Published in:
Outlines

Publication date:
2015

Document Version
Publisher's PDF, also known as Version of record

Citation for published version (APA):
Kristensen, K. A. (2015). Challenging the Conceptual Limits in Health Psychology: Using the Concept of Conduct of Life to Study People's Health Activities from a Social and Subjective Perspective. *Outlines*, *16*(2), 103-125.

OUTLINES - CRITICAL PRACTICE STUDIES

• No. 2 • 2015 • (103-125) •
http://www.outlines.dk

Challenging the Conceptual Limits in Health Psychology: Using the Concept of Conduct of Life to Study People's Health Activities from a Social and Subjective Perspective

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Abstract

This contribution explores the connection between health and subjectivity. Up until recently a marginally discussed topic in health theories, recent critical research in health psychology introduces notions of subjectivity to theories of health. These notions can be linked to phenomenology, embodied subjectivity, and psychosocial theories that have moved away from a partial, internal understanding of subjectivity. These recent theories tend to define subjectivity as a coherence of concrete, embodied and situated subjectivity that extends capabilities and activities towards a world of social relations. The article at hand shows that embodied and situated subjectivity is a basic function of health that sustains the qualities of human life. To comprehend health as a subjective practice in human lives, we need an understanding of people's subjective participation in their everyday social lives. Hence, I will argue for the concept of conduct of life as an important concept for health psychology. The concept of conduct of life enables an analysis of how people conduct their activities and of their access to life possibilities, within social settings and societal power systems. The concept can be used to analyse the connection between subjectivity and health in the cultural and social relations by which people actually live.

Introduction

In health theories, there is a tendency to *divide* the notion of human health up into different concepts, such as mental health, somatic health and social health. These concepts may help researchers with focusing on different parts of health processes. Meanwhile, I argue that health psychology should also focus on the *wholeness* of a human being, instead of merely dividing up the human being according to different concepts. Mental, somatic

and social health should *not* be divided up, but ought to be viewed as *connected processes* in health psychology. Thus, the human being is to be viewed as a whole subject in a social world, and on these grounds, human subjectivity should be considered an *essential process* in human life. My argument is that the concept of *subjectivity encompasses a wholeness of embodied, situated and social being*, and therefore is at the *core of human activities*. So as to theoretically grasp such a wholeness of human health processes, the concept of conduct of life could be a viable conceptual tool to understand health from a subject's standpoint in its daily life.

Theorizing health as everyday life

In the Ottawa Charter (1986), the World Health Organisation WHO states: "Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (p. 3). In this statement, health is understood as a vital part of *people's social lives*. Health is rooted in *supportive social settings*, as in the family home, workplace, and educational institutions (Dooris, 2009). And as I will add: health is *created* in people's everyday lives through their movements in social practices, their learning of abilities, access to social resources and mutual care in social relations. The Ottawa Charter was the onset of a critical health paradigm in the health field, which broadened the perspective on health, with both a social and individual outlook on human health. These broad notions of health pave way for critical theoretical thoughts on how the practice in the health field could be re-considered.

Some of the main problems that stem from classic health psychology are that its theories study the *individual human being* without pursuing a thorough understanding of the individual's *social life conditions*. Another problem I will address is how patients, during medical treatment, feel *neglected* with regard to their subjective everyday life experiences. Medical science emphasises somatic injuries and symptoms and depicts health as individual, somatic and psychic states. The medical paradigm fails to see how people perceive health in their everyday lives. It thus overlooks the major significance of health as part of people's everyday lives. Theories and understandings of health need to incorporate *a subjective view* on inherently social human lives. Against this background, I argue that health psychology could apply the concept of *conduct of life* to analyse health as a social and subjective activity in people's lives.

Sketching the concept of conduct of life

The conduct of everyday life is an important concept in critical psychology. It offers a theoretical lens from the *standpoint of the subject* in its social life (Holzkamp, 2013; Dreier, 1999, 2008; Kristensen & Schraube, 2014). The analytic perspective from the standpoint of a person or a group can be used to analyse people's subjective participation and their social practices in everyday life. In this article, I will shorten the notion of the conduct of everyday life to *the conduct of life*, since throughout my research, I have gradually come to realise that people develop their health as an active life-process over time, and not in a short timeframe of their daily life activities.

The concept of the conduct of life is not only a critical psychological concept. The conduct of life can be applied as a broad concept that renders it possible to analyse people's thoughts, activities and social relations, for instance through sociological, ethnographic, psychological, and phenomenological methods. These methods offer different viewpoints on how people subjectively perceive their activities from within a

social practice. Hence, the conduct of life can only be grasped from a *first person perspective* and be approached by a person who participates in a group or follows a person in his or her everyday life (Kristensen, 2008). A person develops a self-understanding and manages his/her activities in the social practices in which the person participates (Dreier, 1999). Through participatory observation, a person or a group can be explored from within their social conditions, if the observer participates in the social context where persons conduct their lives. From such inter-related viewpoints, the social conditions that influence a person's or a group's life possibilities can be reflected through a mutual dialogue between a researcher and a person, or with a related group of people. Such social collaboration is part of the human *inter-subjective* and *reflective consciousness.* Here people communicate with each other and mirror themselves in the other, or in the cultural and social horizon of knowledge and societal values. By researching such a social intermingling of activities and various perspectives, research in health psychology can interpret how people understand themselves, how they manage their lives and their health in a *changing web of social relations*.

In order to unfold and support my theoretical-conceptual argument, I will selectively analyse theories and current research that emphasises how subjectivity is vital to an understanding of health. I will then discuss different approaches to subjectivity and health: in psychoanalysis, phenomenology, and cognitive psychology. Recent research in embodiment of subjectivity and cognition is analysed so as to exemplify how people perceive their health, and how they cope with illness and social problems. I analyse and productively criticise existing theories of health that discuss subjectivity, followed by a description of critical health psychology as an alternative approach to subjectivity and health. I will present a health theory adapted from Juul-Jensen's (2005) dialectical and historical theory of the concept of health. He argues that the concept of health is a socio-cultural development of various meanings, values and theories about health. The understanding of health therefore needs to be interpreted in the respective historical, social or cultural contexts in which people conduct their lives. Based on this selection of theoretical and research perspectives, I will illustrate and discuss how subjectivity should be understood as a *social and embodied life-process*, ergo a human subject's activities within their social world. On the basis of this theoretical and conceptual argument, I conclude by arguing for the necessity of systematically connecting theories of subjectivity and health with the concept of the conduct of life.

Historical perspectives on health and subjectivity

In this chapter, I will trace the phylogenetic and social development of human health, mainly drawing on Klaus Holzkamp's (1991) analysis of the development of human social nature. My main assertion is that human subjectivity and health evolved through social development in human cultures. The argument is that guarding and self-preservation of life is better suited to a collective structure, in which practice collaboration, mutual communication and safety are supported. The establishment of social communities, self-preservation and mutual inter-subjective cooperation and communication is also observed among other natural beings, for instance in groups of animals, flocks, and insect hives. Communities of humans and animals both produce hierarchical power relations, which affect the possibilities for *survival* and *health* in the oppressed and exploited classes of beings.

The main evolution of human beings has been produced through *collective collaboration*. Over thousands of years, humans have evolved and developed a relative dominance over the natural world. Humans have occupied, accommodated and objectified nature through the *production of life resources*. This was achieved through social cooperation, the construction of dwellings and communities, collaboration regarding food production, tending of animals, etc. The development of collective structures led to the evolution of higher symbolic communication in speech, knowledge, and transcendent mythological narratives of the life-world. This established stronger relations and knowledge in the communities with better prospects of survival and health, via production of tools, life resources and mutual nurturing relationships.

The first human-organized groups were hunters and gatherers (Wood & Richmond, 1999). *Homo erectus* dates as far back as 1.8 million years ago. The Homo erectus scavenged carcasses of large animals killed by predators and collected food in mixed habitats, but hunting was presumably a minor strategy employed by Homo erectus, who crafted hunting tools from stone. This genus died out about 143,000 years ago (Smithsonian National Museum, n.d.). Around 200,000 years ago, the genus of *Homo sapiens* evolved. The process of hunting among Homo sapiens was based on social cooperation, and hence a stage of *developing human subjectivity*. According to Aleksei N. Leontyev's famous example of *Hunter-Beaten*[1] (cf. Holzkamp, 1991), social hunting formed supra-individual collective coordination, where single individuals took on partial functions to reach the goal of the hunt in the social collective. This implies a shared plan, verbal communication, sensibility and coordination as well as the use of physical and symbolic tools between individuals. Holzkamp theorizes that human development evolved from a *phylogenetic stage* through *qualitative leaps* to a *social nature* and a building of socially empowered societies through a *social economy*. The first qualitative leap realized the *inner nature*[2] that made humans *capable of socialization* and "develop into the societal production process" (ibid., p. 52). The second qualitative leap, Holzkamp hypothesised, was a shift from organismic natural adaption to active creation of the environment. However, the qualitative leaps that Holzkamp suggests do not only refer to human's *inner nature,* they also affected the human bodily structure, which was so *flexible* that humans gained the ability to craft tools, communicate knowledge through written signs and through the production of symbolic cultural items. Thus, life production in the form of social labour developed into an appropriation and objectification of nature, in a two-fold constructed objective and subjective social world, built by human beings.

From the nomadic life forms to local social systems, humans developed other societal forms of higher, socially organized civilizations, which were governed by social and political power systems in a *political and social economy*. This governing power was instituted by symbolic, military and economic power, as well as by the inheritance of power positions. The development of societies implied better possibilities of attaining health and prosperity, but on the other side, it also led to strong oppression, slavery and

[1] Leontyev's Hunter-Beaten is an example of collaboration in hunting, where a group of persons produces sounds in order to drive the game towards the awaiting hunters.

[2] I find the term inner nature quite unclear. In the context of the manuscript, I interpret that the inner nature is a development of higher embodied, practical and responsive types of consciousness that co-evolve with social relations, through the development of communication and practices in the human communities.

warfare, which in turn generated inequality, poverty, poor health as well as increasing risk of conflicts and death for the oppressed populations.

Subjectivity and health therapy in Hellenistic schools

In early religious mythologies and philosophy, the concept of subjectivity had some similarity to the concept of the *soul.* The ancient Greeks used the same word for *alive* as for *ensouled*, indicating that the earliest Western interpretations regarded the soul as giving life to the body. Aristotle saw the primary activity of a living thing as constituted by its soul emplaced in its physical body (Nussbaum, 2009). Aristotle assumed human nature to be embodied in a natural and social world, as a part of his spiritual belief in the human soul. The soul was considered the incorporeal or spiritual breath that animates the living organism, and exceeds human death in spiritual after-lives.

In the Greek Hellenistic Schools, the philosophers treated individual health through therapy based on philosophic arguments, through collective lectures and dialectic debates. This provision of therapy was a treatment for darkened emotions, negative desires, knowledge, superstition and false perceptions of the surrounding world. The false beliefs the patients dealt with were usually viewed as problematic social values in society, e.g. a desire for money, competition and status over other people, as well as superstitious perceptions of dangerous spirits and demons and so forth. It was a therapy of the patient's soul to forsake negative desires through arguments, a dialogue for educating the patients in order to develop better abilities and actions to promote a flourishing life (cf. Nussbaum, 2009, p. 15). According to Nussbaum, this form of treating and educating negative subjective desires through arguments and dialogues was an anticipation of later methods, such as subjective forms of therapy and psychoanalysis. Furthermore, I consider the Hellenistic philosophic schools' model of health education through mutual dialogues and arguments to be a precursor of Western health philosophy and health psychology.

Psychological perspectives on health and subjectivity

The following chapter critically discusses theories of subjectivity conveyed in Cognitive Psychology, Psychoanalysis and Phenomenology.

Cognitive psychology and its social extension

Subjectivity was, and still is, partly scrutinised in traditional psychology as an internal cognitive process. As cognitive psychologists Eysenck and Keane (1995) declare:

> [C]ognitive psychology is unified by a common approach based on an analogy between the mind and the digital computer; this is the information-processing approach. In the terminology of the philosophy of science the information-processing approach is the dominant *paradigm* … in cognitive psychology. (p. 1)

The paradigm of information-processing can be understood as the processing and decoding of internal information channels in the nervous system. It is researched through tests and experiments. In psychiatric treatment, child psychiatry, and neurological rehabilitation, cognitive tests are used to measure the cognitive capacities, i.e. the ability

to reason, memorise words, numbers and pictures, the function of the person's work memory and so forth.

Critical psychologist Klaus Holzkamp (2013) criticizes mainstream psychology and herewith cognitive psychology for its standard test design. He claims that this research paradigm adheres to a *worldless* perspective: "*the real, everyday world* which is located in comprehensive meaning contexts and 'in' which we all live, act and gain our experiences is lost to psychology, the test subjects and, ultimately, the experimenter as well" (p. 244). He criticises mainstream psychology for producing restricted data through natural scientific experiments via hypothesis testing, brain scanning and animal experimentations. These test methods are detached from people's subjective life experiences and social activities.

Mainstream cognitive psychology researches how cognitive processes interpret sensorial stimuli and directs the mobility of the human body. The cognitive functions are conceptualized as a *central executive neurological system* that regulate and control a person's behavioural abilities (Baddeley, 1996). Baddeley's and other cognitive research findings show that cognitive functions have a vital impact on behaviour.

Bandura (2004, 1999) includes a social perspective on cognition, and is a main proponent cognitive psychology's vital for importance of promoting people's health. Bandura (2004, p. 144ff.) claims, based on qualitative and statistical evidence, that social cognitive theories operate positively as a method for health promotion. In his theory, he promotes people's self-management and perceived self-efficacy. He argues that the individual can change his or her habits if they are *motivated* and have *sufficient knowledge of health*. Bandura argues that citizens do actually *need guidance and help* from professionals. He states that, "the revolutionary advances in interactive technology can increase the scope and impact of health promotion programs" (p. 149). Thus, health guidance can be disseminated over the internet as a self-management programme, without larger interference in peoples' everyday schedules, where people can choose a suitable time and place. Bandura believes that people must be *individually involved* in their own health practice to create the possibility of change. It is not enough that health services and health practitioners take primary responsibility for citizens.

More generally, Banduras' *social* cognitive theory investigates how social relations and information can change a person's habits through cognitive self-management. A person's habitual dispositions are influenced by social systems, in the sense that political and social systems can prevent illness. Bandura therefore argues for structural changes to social systems to defy impairment of health and further people's possibilities for establishing a sound habit. An example is the prohibition of smoking in institutions, schools and workplaces, which led to a decrease in the number of smokers.

Similarly, in my current research, I find that children with major functional disabilities do need professional social educational help to develop their cognitive and embodied functions (Kristensen, 2013; Kristensen & Holm, in preparation). To develop the children's cognitive and bodily functions depends on a stable and foreseeable environment with continuing assistance from skilled professionals. Their bodily, subjective and social capabilities develop in a social and educational environment, through which the children gain abilities to manage their lives and understand themselves. Their ability to function in everyday life and are the main condition for their wellbeing and health.

Freud's psychoanalysis and subjectivity

Freud was the first psychologist to thoroughly research innate psychological processes, independent of religious pretensions, through a hybrid of empirical science and theoretical speculations (Westen & Gabbard, 1999). As a neurologist, educated in natural science, he theorised the psyche to be an energy system in which psychic energy exerted pressures, as if there existed a hydraulic fluid of the mind. He believed these psychic forces to be instincts, such as Libido, i.e. the life instinct (self-preservation and sexuality), and Thanatos, i.e. the death instinct (aggression, harm of self or others). Freud theorised these instincts as innate drives that powered human behaviours (Larsen & Buss, 2002). He argued that the majority of the internal psychological processes were unconscious, both a repression and a defence mechanism of unacceptable urges and feelings that would create unwanted behaviours, thoughts and feelings. The conscious mind and pre-conscious mind constituted relatively minor parts of the psychic topology. In his therapeutic research methods, he developed a meta-psychological theory on personality structures and child development.

Freud would later be criticized for developing speculative concepts in his meta-theory. For example, Fromm criticised Freud's internal biological motivation theory of libido and aggression as well as his negative view of human nature. He argued that Freud had neglected the fact that humans are historically and culturally situated as pro-social creatures (Westen & Gabbard, 1999). Recent neo-analytic movements also criticise Freud's psychological and biological meta-theory as being based on vague empirical results, with an excessive belief in the unconscious, grounded in theoretical beliefs and controversial case studies (Larsen & Buss, 2002). They developed his analytical method further by promoting a more equal relationship and dialogue between analyst and patient (Jørgensen, 2012).

The main point here, though, is that Freud opened up for accessing subjectivity through a *psychological therapy* of people who suffered from psychiatric disorders or life problems as a treatment of mental health disorders. He did initiate an introspective treatment of people's neuroses and anxieties, revealed in pathological behaviours and conflicts, by combining biological, philosophical and psychological assumptions on the unconscious and conscious. His intention was to help people to become conscious of repressed thoughts and instincts, and to free them from psychological suffering and behavioural problems. Regrettably, his ideas promoted a long-standing *innate* understanding of subjectivity. It produced a *third-person interpretation* and perception of the unconscious of a subject's actions and self-understanding. His talking cure exemplifies a one-sided interpretation of the patient's free associations that did not provide possibilities for the patients to *influence the interpretation of their own utterances.*

As mentioned, Freud's theories have been strongly criticised as a rather unsubstantiated meta-psychology, although Freud did partly initiate a budding paradigm of psychological and social research about subjectivity through qualitative methods. He also explained that psychological structures are developing from child to adult through the child's family or other close relations. Hence, his concept of subjectivity partly considered the relevance of *social relations*. The internal psychological (mainly unconscious) structure was influenced by the person's everyday life with others.

Husserl's phenomenology and subjectivity

Contrary to the third-person interpretations and instinctual assumptions in Freud's theories, Husserl founded a phenomenological movement which analyses the conditions of a person's experiences and conscious perception of given phenomena in a life-world through a first-person orientation. The young Husserl, who had previously studied mathematics, firmly believed in phenomenology and the interpretation of phenomena as a strictly *philosophical* discipline. He stated that the phenomena should be investigated *without any pre-understanding*, through an *analytical reduction* of prior experiences and judgements. This should allow an examination of the real substance of the phenomenon, free from pre-judgements (Zahavi, 2011).

Husserl's phenomenology was a continuation of Kant's analyses of the *thing-in-itself* in his *Critique of Pure Reason* (Kant, 2004). According to the young Husserl, consciousness and experiences are intentional. In the human consciousness the intended phenomenon is experienced and interpreted in a mental act that produces meaning and judgements. The conscious human perceives anything, any object, sound or relation etc., from a particular perspective as a phenomenon, and cannot grasp the *thing-in-itself* in its pure material existence. Therefore, human beings perceive the world as a web of phenomena through their learned pattern of experiences. Subjectivity could herewith be thought of as a *vague form of knowledge* when compared to the natural sciences, the latter using so-called neutral and objective methods to reveal *true reality*. However, the perceiving of the world through experiences and knowledge is a condition of practical use in human perception and understanding. The human consciousness is not a *neutral objective process*, it interprets phenomena subjectively. The interpretation of phenomena matters as the *true reality* for human beings. In this world of activities, and weaving of social relations, people experience themselves subjectively in the world through their *common sense* perception of *reality* (Berger & Luckmann, 1991).

Phenomenological methods have advanced health research, and in particular Nursing Research, throughout the past 50 years. For instance, Wojnar & Swanson (2007) state: "At the core of phenomenology lies the attempt to describe and understand phenomena such as caring, healing and wholeness as experienced by individuals who have lived through them" (p. 273). Nonetheless, Wojnar & Swanson criticise the individualistic perspective which solely focuses on people's experiences. They further argue:

> [W]hen we consider what is it like to experience caring, healing, and wholeness we cannot ignore the lives people live outside of being ill or well. In fact, their very experience of health is in the context of family traditions, community values and the broader socio-political context. (p. 174)

Wojnar & Swanson's critique is directed at Husserl's early strict analysis of the internal human consciousness and experience. In his late period, however, Husserl expanded his theory into a *sociological phenomenology* (Zahavi, 2011). He theorised people´s participation in a life-world, their inter-subjectivity, the influence of historical traditions, the legacy of knowledge in the human collective experiences and inter-subjective relations. This was mostly a conceptual and philosophical analysis about human experiences and consciousness in a life-world. Irrespectively, many of his conceptual tools were put to use in sociological phenomenology, ethnographic and sociological theories.

The resemblance between Freud's and Husserl's perspectives on subjectivity is relatively contradictory. Freud's belief in biological psychic instincts and an unconscious process that intervenes into human thoughts, desires and actions, needed external interpretations in order to reveal unconscious drives interfering with human conduct. Freud's notion of an unconscious process was different from Husserl's understanding, in that human conduct is based on conscious and intentional processes in which persons relate to phenomena and objects in their surroundings. Although they had very different perspectives on the concept of subjectivity, they both emphasized the importance of inter-subjective relations in a social world. Nevertheless, the notion of the unconscious should not be wholly rejected, but should be analysed with other perspectives than the Freudian ideas of a repressive, instinctive and unconscious psychic process.

Discussing the notion of the unconscious as a peripheral consciousness in people's perception of their health

In the next passage I will convey other perspectives about what could be termed knowledge and experiences that are *peripheral* to the human consciousness. These peripherals play an important role in people's perception of health.

Schütz and Luckmann analysed in a phenomenological and sociological perspective how people perceive their *social reality.* They stated:

> The world of everyday life is consequently man's fundamental and paramount reality. The everyday life-world is to be understood as, that province of reality which the wide-awake and normal adult simply takes for granted in the attitude of common sense. (Schütz & Luckmann, 1973, p. 3)

The notion of common sense denotes our awareness of what we *take for granted,* but can we take any experience or phenomenon for granted? Husserl's method of an analytic reduction (epoché) of a phenomenon could be used in order to study how we interpret a phenomenon to shield it from the pre-judgements we take for granted in our everyday experiences. This method of reduction could suspend the common sense pre-judgement of a phenomenon, and change a *biased perception of a phenomenon.* It shows that our consciousness is also influenced by the social values in our historical and cultural contexts.

In his early work, Sartre (1991) criticised Husserl's reference to an evident *self-conscious I*. Through a phenomenological analysis, he argued that knowledge of our selves is not self-evident. The ego is *also a phenomenon*. Grounded in Husserl's ideas, Sartre argued that the human consciousness is a *transparent stream of different conditions of consciousness*. He understood consciousness as a *free floating state of reflection*. If we had an *opaque I*, it would impede the streaming of psycho-physical states of consciousness. It would obstruct the reflecting consciousness. According to Sartre, the ego is therefore a *transcendent object*.

Here, the question becomes: How can we fully know ourselves? Do we always reflect on *who we are*, and how other persons' experience and judge us? When we try to describe ourselves to other people, or write a job application, can we altogether describe ourselves? This is what I term a *Sisyphus question*. We carry the understanding of ourselves uphill, and fall down again in a *continuous process of self-understanding*.

We reflect on ourselves as an object, a phenomenon which does not reveal a full understanding of who we are. We mirror ourselves in social relations and in the social practices we are a part of (Burkitt, 2008). Health is a *vital part* of this recurrent reflexive self-interpretation. Am I healthy and normal in the eyes of others? Do I feel healthy or ill? How do I or others interpret my condition? Can I at all evaluate my healthiness, if I do not clearly know who I am? So, a view on the peripheral consciousness could be that we cannot be fully aware of who we are and then cannot be fully aware of our state of health. Our perception of our health is a *process of continuous reflection*.

The Embodiment and Situating of Subjectivity and Cognition

In this chapter I will show that recent research paradigms on subjectivity and cognition went from an innate perspective to a wholeness perspective of subjectivity, in which subjectivity is conceptualised as an embodied and situated human activity, contained in a biological organism. This will be further explained in the following sections.

Toward a social understanding of subjectivity

In a cognitive research project by Clark & Chalmers (1998), the concept of *extended mind* is introduced. They state: "When humans are appropriately linked with external entities, the whole arrangement constitutes a cognitive system in its own right" (p. 29). They conceptualized this as an *active externalism* that "concerns the active role of the environment in driving cognitive processes" (p. 27). The approach offers an active and situated perspective on cognition in an environment. The concept of extended mind has provided a new research paradigm for the cognitive sciences, which extend cognitive theories from an innate information process towards a whole system of perceptual activities in the social surroundings.

Similarly, in Critical Psychology, the concept of subjectivity is theorised as integrated in a person's social activities and practices. It is a critical psychological paradigm of theories and research that argues for a psychological conceptualisation of people's activities in their social contexts. Psychology should not study innate cognitive process of thoughts and feelings. It should comprehend human psychology from the standpoint of the subject in his/her activities in the everyday social contexts. Subjectivity is a societal realisation in which an individual subject adapts to collective, inter-subjective relations of social activity, knowledge, values and political power systems (Holzkamp, 1979).

The discursive, critical psychologists Hepburn and Jackson (2009, pp. 177-178) also argue for locating causes of subjective behaviour in situated, social, political and cultural contexts, where people act subjectively through talk in social interactions. They criticize theoretical approaches that solely focus on subjectivity as internal psychological states. Language in social communication, knowledge and thoughts are firmly grounded in the consciousness of human subjectivity. Activities, perceptions and experiences that go beyond what can be phrased in learned language, are also a fundamental condition of subjectivity (Schön, 1983). An example of this is that it is not only social relations, language and habits that change subjectivity, but subjectivity is also mediated by tools and technology that extend the capabilities of a person, and thus transform and extend the human's possibilities for action (Schraube, 2013). However, the ability to act through language and with technological artefacts is grounded in the human body. This may be a

reason for why Thomas Teo (2009) calls for the *"necessity of embodying theories of subjectivity"* (p. 40).

The Phenomenological and situated embodiment of subjectivity

The situated and embodied cognitive research has taken a rather late turn. The perspective of embodied and situated experiences had already been thoroughly analysed by Husserl and later expanded by Merleau-Ponty in his philosophic explorations. Husserl contemplated on the phenomena of the dual perception of human embodiment: a *performative body* and an *opaque body* as a structure of activities and consciousness, and an experience of a phenomenon of our physical structure (cf. Legrand, 2007). Husserl extended the theory of the individual's consciousness through a social analysis of human inter-subjectivity in a life-world (Zahavi, 2011). Merleau-Ponty (1962) analysed the relation of embodiment, perception and subjectivity. In an analogy, he asserts the rootedness in a world that consequently besieges the embodied subjectivity, with perceptions that provide the conditions of knowledge:

> [W]e have present at this moment to us a perceptual field, a surface in contact with the world, a permanent rootedness in it, and because the world ceaselessly assails and beleaguers subjectivity as waves wash round a wreck on the shore. All knowledge takes its place within the horizons opened up by perception. (Merleau-Ponty, 1962, pp. 240-241)

The concept of *Dasein* was introduced by Husserl's student Martin Heidegger (2012) in his widely acknowledged treatise, *Being and Time* (originally published in 1927). Heidegger sought to analyse the ontology of *being*, which he argued was neglected in philosophy. Heidegger claimed that the ignored essence of philosophy was the very understanding of being. He said that being is not just any question, it is *the* question. His analysis revolved around the concept or structure of *Dasein*, i.e. being-in-the-world: a unity between the living being and the world. His ontological perspective on being encompassed being-in-the-world, knowing, experiencing and the pre-reflective everyday activities of the world-at-hand. The ontological structure of Dasein, he argued, consisted of *care* and *concern*, but not care of one's own health: It is rather a concern and precaution whilst carrying something out – a concern about the success of the undertaking of the project of being. His central example is an analysis of anxiety, where he argues that we are preoccupied by concern and anxiety of what the future brings. Our projection of future trials is, meanwhile, also founded in our memories and past life-experiences.

Heidegger thus asserted that the question of individual existence in Dasein is revealed through a historical process of existing, not as a *current contemplation of our existence* (cf. also Munday, n.d.). This implies a philosophic analysis of *who we are*. The question of who we are is not answered by a reflection of our *contemporary being*, but instead of *what we hope to be* (Burkitt, 2008). Our contemplation of our own health is also a self-conscious reflection we project into the future. What can I do to enhance my health? What can I do to promote my well-being and life-quality? These questions are based in how we *predict* what the changing scenarios of our social situation will look like in the near future. Meanwhile, according to Zahavi (2010), Heidegger's theory was quite vague in its descriptions of an *embodied being*. It was a rather philosophic and linguistic

conceptualising of *an anonymous being* that experiences and reaches out into a world-hood.

A closer analysis of this relation, instead, would require a study of an *embodied being* in a world-space. Merleau-Ponty (2005) states: "Our own body is in the world, as the heart is in the organism: it keeps the visible spectacle constantly alive, it breathes life into it and sustains it inwardly, and with it forms a system" (p. 235). In his analogy, *the body* is the systematic centre of perception and being, which was omitted in Heidegger's monograph. In order to experience something, an object, relationship, a sound or another person, it is necessary to *be in the space* in which the phenomenon appears. Every phenomenon faces the experiencing subject in a profile or in a fragment. It implies that the experiencing subject must be located in the presence of the phenomenon, through the subject's bodily position. Heidegger inferred, though, that the physical space was not very significant for the experience of phenomena. The perception of space was not a physical measure, but could just as well be a Skype conversation with the other side of the world, a telephone conversation, or the recognition of a friend at a distance. However, if we talk on a phone or see a friend at a distance, the placement of the subject is the core where the space extends from, and therefore the position by which phenomena, or an object, can be experienced and handled (Zahavi, 2011). The body is thus a condition of the coherent linkage between movement, and activities, as well as of the contingency of possibilities in a *life-space* (Lewin, 1936).

Another reflection by Husserl deals with the *bodily experience* of subjective corporeality in action and the objective experience of the body as our own physical structure. The body can be felt and watched from its outside senses as a phenomenon, and felt from the inside as sensations, such as a feeling of excess, well-being, pain, disease or tiredness. This clearly demonstrates that the embodied subject experiences its own condition as the particular state it finds itself in. Feeling a state of being is coherent with the subject's awareness of its environmental circumstances. It can be a state of well-being, comfort or misery, or a lack of security, e.g. in a work environment or in family relations. Diverse sensations in an environment can lead to positive or negative experiences. Thus, embodied and situated subjectivity is a vital part of *experiencing and appraising states of health and well-being*, and an important indicator of how to manage and conduct life relations in conflictual, social practices.

A last voice I want to include in this exploration of the embodiment of subjectivity is biologist and philosopher Humberto Maturana. Maturana researched the structure of living systems. He defined cognition as a biological phenomenon, and argued that living systems were "autonomous, self-referring and self-constructing systems", as written by Cohen and Wartofsky (1980, p. v) in their preface to Maturana's (1980) monograph, *Autopoeisis*. He then defined these systems through his invention of the term autopoeisis, which denotes a *self-creating/producing* living system. According to Maturana (1980), a living biological system is *self-referring* in a circular biological organisation. This circular system affects a class of the organism's *entire interactions* in a niche of an environment. "Thus for every living system its organisation implies a prediction of a niche, and the niche thus predicted as a domain of classes of interactions constitutes its *entire cognitive reality*" (p. 11; my emphasis). In living systems, cognition and perception function by observing and sensing *internal* states and *external* relations in the surrounding environment. Thus, the observing and sensing states and relations produce knowledge of an environment, which help with communicating with other beings and with becoming aware of positive or dangerous

situations. The embodied cognition creates impressions of an environment, of other beings, and the beings' consciousness of its self. By this awareness of the environment, an animal or a person will be able to act with care.

I find that Maturana's theory shows that being is *not only behaviour,* but a psycho-physical activity. This activity is *conditioned* by an evolving of *biological and cognitive capacities* in a *bodily structure*, adapted to a particular environment. These embodied and cognitive capacities are *important for health*. Animals have evolved embodied skills in an environmental niche that help them to adapt to their surroundings. The cognitive capacities are a biological function. Animals can utilise the cognitive observation of the surroundings to find food, maintain awareness of their safety and relate to other beings. This can be seen as subjectivity in all living beings, which is vital for the upholding of life and health.

However, most animals are closely biologically adapted to a certain environmental niche. In their highly evolved subjectivity, human beings are *better suited to adapt to changing circumstances*, through their collective abilities to communicate, learn, cooperate, create tools and produce life resources. Thus, human biological and collective capacities exceed the dependency of a certain environment through the human ability to manufacture vital life resources and live in different environments. My argument, then, is that the general human ability to adapt to changing circumstances is a basis for better possibilities for doing health.

Health as an embodied subjective life-process

The overall conclusion of this latter part is that there is a new perspective also in the cognitive sciences, one that focuses on the situated and extended mind. This perspective comes close to the early conceptualisation of Dasein, in which the human subject is embedded in the wholeness of its social world, as an active embodied relation to its social world, and *not only an individual condition*. Hence, the notion of health should be considered as an *active life-process* relating to the subject's social world. In this perspective the bodily, physical and sensorial capacities constitute a *unity* of consciousness and movement in a living being. The embodied subjectivity is central to the *sphere of possibilities* in the subject's surrounding world.

Still, neither the extension of the mind theory nor phenomenology include an analysis of the subject's social surroundings and of how these social circumstances are interpreted by the individual in his/her understanding of one's health. While the concept of Dasein analyses the individual being and its being in the world. It does not encompass the social conditions or political systems. However, it could be a viable *analytic sub-concept* for a theory, building on the conduct of life concept, in its perspective on being/living in the world. The psychological-cognitive research and Dasein, to a minor degree, include the embodiment of the subject. Both theories arguably open up for a more comprehensive analysis of how people act and experience themselves as a part of a world-hood across diverse fields of psychological research.

Meanwhile, avoiding a theorisation of the embodied subject in its social conditions runs the risk of leaving a subject *anonymous*. The anonymity of the subject in the concept of Dasein is quite close to the anonymity of a subject in the concept of *conduct of life* as it is usually conceptualised. Conduct of life is an *open analytic concept* that enables interpretation of how people live in various cultures with different forms of individual

capacities. It offers an open and *non-normative* analytic framework to explore the conduct of life, in and across various social and cultural practices. However, I find that it currently lacks an analytic view on the significance of the embodied capabilities of a person in a social practice, in order to further an inquiry into a person's concrete conduct of life.

So as to proceed from anonymity to a subject's identity, the *embodied presence* and social identity of the subject needs to be more closely analysed. Is the subject a child, a woman, a man, a homosexual? Is it handicapped? Is it a foreigner, a person of another ethnic constituency? Which historical, social relations and cultural circumstances is the individual part of, as well as influenced by? How does the subject present her/himself in an inter-subjective relation? How is the subject met and recognised by others?

The locating of the bodily subject entering into social collectives, where other people relate and evaluate an individual's abilities, appearance, communication, charisma and friendliness or agreeableness, is pivotal. The encounter with other people, in particular contexts, leads to self-awareness: How am I known? Am I met with recognition or rejection? Am I invited into the community? A person can evaluate him or herself in a collective and through contact with other people. This has positive consequences for obtaining possibilities of being included in social relations, access to vital social resources, and for a person's mental health and self-worth.

Conduct of life as a theoretical extension of health psychology?

The first chapters of this article traced notions of individual subjectivity in cognitive science and phenomenology and argued for phylogenetic-historical as well as embodied-situated analyses of subjectivity. In this upcoming chapter, the connection between health and subjectivity will be analysed through existing health theories. Hence, I will analyse two health definitions that incorporate a sense of subjectivity.

In order to analyse the relation between subjectivity and health, I will throughout these final pages argue that the concept of *conduct of life* can be a very useful concept for health psychology. Conduct of life offers a perspective from *the standpoint of the subject* in its social circumstances (Holzkamp, 2013, 2016). It integrates the subject's self-understanding and understanding of its participation in social practice structures (Dreier, 1999). What people find meaningful can be grounded in various beliefs and perceptions within social practices. It is seldom a utopian and unattainable project, but rather a discernment of what makes common sense in a person's contemporary situation. It is a kind of cost-benefit analysis that colonises a person's perception of the accessible possibilities, in their sense of reality.

The conduct of life allows for an empirical investigation of the subject's realising of its life practices and hence its *qualities* in life. The subjective perspective should not be understood *individually*, it should be understood *inter-subjectively* in the different social contexts and practices, where the person participates in her/his course of everyday life. If a person should maintain health and well-being, he or she needs to learn to organise their changing participations in social practices. The concept of the conduct of life can be used to study how a subject tries to pursue and develop a valuable life, with health and well-being as vital outcomes.

Subjectivity in Nordenfelt's and Antonovsky's health theories

In order to study people's health activities, it is impossible to avoid a conceptualisation of subjectivity in health theories. Even if there are theories that define health negatively as simply being free from illness, handicap and vulnerability (Boorse, 1977), such theories are dependent on human experiences of body symptoms and problems with physical and psychological functions in everyday life, so as to establish diagnoses, health examinations and evaluations of the effects of a treatment.

Nordenfelt (1987) defines health from an *action theory perspective*: "A person's health is characterized as his *ability to achieve his vital goals*" (p. xi). Nordenfelt does state, however, that there is not a clearly definable concept of health. There are, nevertheless, highly inter-related forms of the concept (pp. xii-xiii). Producing *tentative definitions* can help progress towards understandings of health in health practices. For instance he discusses what the meaning of *vital goals* are: a) the vital goals of man can be deduced from his vital needs (need-theory); b) the vital goals of man are identical to the goals that he himself sets during the course of his life (the subject-theory). Through a critique of these tenets, he concludes that "the vital goals of a human being are goals whose fulfilment is necessary and jointly sufficient for the minimal happiness of their bearer" (p. xv). He gathers that minimal happiness requires normal circumstances, i.e. neither war, nor conflict, nor disease. The vital needs can be supported by family and healthcare personnel.

I consider Nordenfeldt's concept of happiness as a *sign* of health, within his broader theory of *welfare*. This tentative notion of health connects capabilities of vital goals in life with the subjectivity of happiness. The concept of happiness is hardly a *core process* of health. It is rather a sign of welfare, in a subject who manages well in life.

A second health theory, which explicitly conceptualizes subjectivity, is Aaron Antonovsky's theory of the *sense of coherence* [SOC]. He argues against the perspective of pathogenesis in health practices and takes a view on the processes of health that prevents stressors and illness, which he terms *salutogenesis*. His definition of SOC is:

> A global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement. (Antonovsky, 1987, p. 19)

The complex concept of SOC has three components: *comprehensibility, manageability,* and *meaningfulness.* Comprehensibility is the understanding of internal and external stimuli. Manageability is the ability to cope, be supported, and control events and situations in life. Meaningfulness is the strong belief of a purpose and meaning in life. Antonovsky found that the concept of *meaning* was essential. It is the basis of motivation and purpose in life to fight problems as challenges. He argued for qualitative methods to understand the stressors and problems in people's life situations, through biographic interviews. The threefold concept of SOC suggests a phenomenal investigation of people's management of stressors in their life circumstances, and their capacities to prevent stress and illness.

The health theories by Nordenfelt and Antonovsky are theories of practising health through active human subjectivity. They both emphasise the individual's activities, for example the active relating to values, meanings and purposes on the grounds of their life conditions. However, the theories underdetermine the actions of people in contextual settings, and tend to be normative in defining individuals' health. Although the theories have contemporary and contextual merits, they do not incorporate wider notions of health in other historical and cultural contexts. Albeit these conceptual theories can help point out important psychological factors in health, their perception of health needs to be *extended by empirical research* in the different social or cultural contexts, where people *actually conduct their lives*.

Juul-Jensen's dialectic health theory

Philosopher Juul-Jensen (2005) argues for a *dialectic* and *historical* theoretical understanding of the health concept. In this approach, the diversity of health concept stems from changing historical, cultural and local factors. Through his dialectical analysis of differing historical and cultural life-forms, he asserts that the concept of health should be viewed as a *plastic linguistic sign.* He then argues that health is not a universal or essentialist concept. This is substantiated through the multiplicity of health definitions and cultural perceptions of health.

These different cultural perceptions could be analysed via social constructionist methods. However, social constructionism could be criticised as a *relativistic* perspective: Do all social and cultural values truly make sense? Still, social constructionism can analyse a complexity of social and cultural discursive notions of health within a particular social context, and then analyse these notions critically. It could be seen as closely related to dialectic health theories. The historical dialectic perspective does also open up for opposing perspectives of health, but it is not *entirely relativistic* because it generates a *synthesis of knowledge* over time. It does not unify opposing cultural or social perceptions, but interprets a *conceptual core of consensus* between opposing theories or cultures. Over time, it can synthesise knowledge of opposing forces, in the *balancing point*, where they meet and struggle.

From this dialectical perspective, Juul Jensen (2005, p. 16) claims that a synthesis of the differing concepts and perceptions of health is bound to the concept of *life*. The concept of human life does not offer a unified conception. Rather, it is a multi-faceted conceptual notion. There is a high level of diversity between the billions of people in the world, living in very different social situations. It is therefore indisputable that human life is complex. Juul-Jensen argues that to understand health as a process in life, we should interpret the different perceptions of *qualities* in life. Such qualities have *different meanings* in various social and cultural contexts. His theory offers a conceptual openness to how *qualities in life* are changing through history and in individual life-forms. Therefore, an analysis of health or qualities of life should be empirically interpreted from *within the social or cultural settings in which people live.* Thus, the analytic and empirical concept of conduct of life and related methods can help to analyse the perceptions of health, i.e. the qualities of life, in various historical, societal and cultural locations.

Subjectivity in critical health psychology

Critical Health Psychology [CHP] works out critical alternative theories and practices against traditional mainstream health psychology. Critical theories and perspectives on

health operate primarily within the social domain of citizen groups that are badly off in life. They are in the public media stigmatised as a separate class or a category of a group of humans. This could for instance be sex workers, drug users, unemployed, war refugees, homeless or dysfunctional persons. The aim of CHP is to offer an understanding of social conditions and social help, as mandatory condition for shaping a life of well-being. It analyses health problems for people with psycho-social problems, few material and social resources, and who are alienated from social recognition.

In a review of CHP, Chamberlain & Murray (2009) present methods to treat poverty and the lack of social recognition through means such as art, theatre, documentaries and literature. The idea is to attract popular media and to rouse the public and politicians so that they may understand the social predicaments (such as poverty) that are impacting health and well-being. Via such methodological approaches, the involved groups can convey *authentic voices* in the light of their difficult social conditions. In these social collective therapeutic practices, the involved participants stand out with their subjectivity narrating their stories. Playing them out in art, theatre or documentaries, for example, can provide a detailed description of the participant's perception of their lives in relation to their life conditions. The participants, then, reach out to an audience, in order to illustrate their subjective standpoint in their life story and everyday conduct of life, and to find recognition in the group collective and in relation to a public audience. It is a way to *de-stigmatise* a person, and understand how the person gets stuck in a problematic state of affairs.

The idea behind the use of narratives in theatre, pictures and literature is to change social and political structural problems that lead to unhappiness and an unhealthy and unfulfilled life. In Freire's (1993) book *Pedagogy of the Oppressed*, the marginalized groups were taught to stand together and to develop a *critical consciousness* of the historical social predicament in which they find themselves (cf. also Guzzo, Moreira & Mezzalira, 2015). It is an empowerment method for groups to struggle against the political field of oppressive powers, and shape possibilities for changing their understanding and social situation through collective actions and knowledge. The groups communicate their intimate everyday knowledge and their subjective forces, to better be able to *collectively express the problems in their social situation*. It can be analysed as a *subjective voicing* of individuals and groups in their conduct of life.

The marginal awareness of human subjectivity in medical practice

In medical treatment, there are problems identifying people's understanding of their everyday life. The doctor asks the patient about his or her symptoms at the beginning, during and at the end of a treatment. Throughout these inquiries, the patient's symptoms are normally articulated as bodily sensations, separated from a wider contextual understanding. Medical treatments do have a vital importance in the health field. The health systems ensure better life possibilities for the population. Medical treatments are a scientific, highly skilled and educated craft for a somatic cure. Corporeal diseases cannot fully be perceived through the superficial analysis of symptoms. It requires somatic examinations such as X-ray, scanning, and blood tests to examine interior injuries. Somatic treatment is analogous to performing a check-up on a car, repairing a bicycle or updating a computer. It can produce better physical and psycho-social functioning, but the

somatic perspective leaves little time to investigate the problems in everyday lives. Many patients therefore become frustrated by the doctor's dominance over medical treatment and medicine prescriptions, also their reluctance to inquire into the patient's social situation and stressful symptoms, which are of crucial importance for understanding the patient's changing functionality in everyday life. The health problem could (also) be related to anxiety about losing a job, a partner or losing potential welfare subsistence.

Research shows that patients often complain about the doctor's lack of investigation of the patient's life situation throughout medical examination procedures (Elsass, 1992). Even though scientific medical methods have strong effects on some diseases, the proportion of suffering patients has not decreased. Many contacts with the medical system are initiated due to minor somatic symptoms, relating to stress and psychological problems and anxieties in everyday life. Thompson (1984, referenced in Elsass, 1992) found that patients' discontent leads to a large proportion of patients who do not follow the doctor's treatment prescriptions, which in turn leads to less effective treatment processes. These patients experience a higher level of side effects. This means that many patients return to the doctors to be treated, or alternatively change doctor because they are discontent with their treatment (Elsass, 1992). However, the pressure caused by the high numbers of patients rarely gives time for engaging in dialogue about the social problems in the patient's life situation, because the brief time available is normally exclusively devoted to medical treatment procedures.

The WHO's Ottawa Charter (1986) developed a broad health concept, in which health is conveyed as part of a person's active and productive process of living. On the grounds of this broad perspective on the concept of health, practitioners and experts should adjust their perspectives to *an understanding of people's participation in everyday life*, from people's subjective perspectives on their values and participation in a social world (Potvin & McQueen, 2007). McQueen (2007) criticises health science for their lack of consistent theorising of how people perceive health in their social contexts. Since all human actions are produced in social contexts and relate to social practice, the medical somatic perspective alone is hardly sufficient. This is because the behaviour of a subject and interventions of health-care *change* the relations of health in the conduct of everyday life. McQueen asserts that "health promotion theory *cannot be based on a notion that the whole can be reduced"* (ibid, p. 34). Reductionist methods for investigating human actions do not produce valid knowledge across social contexts. Research into health practice should instead focus on the process of people's *subjective activities and participation* in the flow of structural changes in social settings.

I therefore argue that causal explanations of the activities of people's health practices do not explain *dynamic changes* in their conduct of life. These explanations cannot comprehensively conceptualise the complexity of human health processes. It requires qualitative methods that account for people's concrete situations within their life-settings. The practice of health is produced by people's participation in everyday life in a process of self-management, social nurture and social systems. It happens within social contexts in a nexus of social powers (Potvin & McQueen, 2007).

Concluding thoughts

My argument is that health can be conceived of as an embodied and situated life-process in the conduct of life. The major theories of health psychology tend to concentrate on the

individual's mental health, positive or negative feelings, cognitive capacities, and health behaviour. However, to *conduct* an everyday life is an *embodied inter-subjective performance* in a social world. In a modification of an analogy of Merleau-Ponty (1962), I state: Embodied subjectivity is the *heart* of human practice, and therefore a vital structure for the preservation of human-life qualities. The practical realisation of everyday life is placed within a world, its practice structures, social relations and political systems. Thus, subjectivity is not an individualistic concept, but encompasses an embodied relational existence, where people move and change in the course of social activities across the structures of a life-world. The concept of *conduct of life* can be used to analyse people's perception of their health and life qualities, in their everyday cultural and social settings.

Due to historical changes, cultural and individual differences, health cannot be defined as an absolute concept. It is a multi-faceted process situated in various individual, social and cultural circumstances. The definitions of health need a dialectical analysis of the qualities in human lives. Research definitions can approach the concept of health from various angles and help communicate and understand vital processes of human life. In this context, the open concept of conduct of life can be a valuable concept through which we can analyse the connection between health and subjectivity in the practising of human lives. The pathological or somatic medical perspective does not adequately conceptualise health, because the practice of health is also an active and conscious structure grounded in human social practice. Meanwhile, medical treatment and human practice are dialectically dependent on each other and should merge subjective and objective perspectives in the practice of health. The subject's conduct of life is dependent on access to life resources, social recognition, avoidance of unstable social conflicts and oppression. A human subject is not merely a solitary living being, it is also an *embodied subject,* subjected to a world of social powers. This leads to the necessity of public and political (health) organisations to create collective empowerment through promoting better living conditions, within the social structures of societies.

References

Antonovsky, A. (1987). *Unraveling the mystery of health: How people manage stress and stay well*. San Francisco: Jossey-Bass.

Baddeley, A. (1996). Exploring the central executive. *The quarterly journal of experimental psychology, 49a* (1), 5–28.

Bandura, A. (1999). Social cognitive theory of personality. In A. L. Pervin & O. P. John (Eds.), *Handbook of Personality* (pp. 154–197). New York: The Guilford Press.

Bandura, A. (2004). Health Promotion by social cognitive means. *Health Education & Behavior, 31*(2), 143–164.

Berger, P., & Luckmann, T. (1991). *The social construction of reality: A treatise in the sociology of knowledge*. London: Penguin Books.

Burkitt, I. (2008). *Social selves: Theory of self and society* (2nd ed.). London: Sage.

Chamberlain, K., & Murray, M. (2009). Critical health psychology. In D. Fox, I. Prillentensky & S. Austin (Eds.). *Critical psychology: An introduction* (2nd ed.) (pp. 144–159). London: Sage.

Clark, A., & Chalmers, D. J. (1998) The extended mind. *Analysis, 58*(1), 7–19.

Boorse, C. (1977). Health as a theoretical concept. *Philosophy of Science, 44*, 542–573.

Dooris, M. (2009) Sundhedsfremmende settings teori, politik og praksis. In M. Carlsson, B. Bruun-Jensen & V. Simovska (Eds.), *Sundhedspædagogik og sundhedsfremme: teori, forskning og praksis* (pp.277–294). Aarhus: Aarhus Universitetsforlag

Dreier, O. (1998). Client perspectives and uses of psychotherapy. *The European Journal of Psychotherapy, Counselling & Health, 1*(2), 295–310.

Dreier, O. (1999). Personal trajectories of participation across contexts of social practice. *Outlines, 1*(1), 5–32.

Dreier, O. (2008). *Psychotherapy in everyday life*. New York: Cambridge University Press.

Elsass, P. (1992) *Sundhedspsykologi*. Copenhagen: Nordisk forlag.

Eysenck, M. W., & Keane M. T. (1995). *Cognitive psychology: A student's handbook* (3rd edition). London: Erlbaum, Taylor & Francis.

Freire, P. (1993). *Pedagogy of the oppressed*. London: Penguin.

Guzzo, R. S. L., Moreira, A. P. G., & Mezzalira, A. S. C. (2015). Everyday life and public elementary school in Brazil: A critical psychological intervention model. Outlines – Critical Practice Studies, Vol. 16 N. 2.

Heidegger, M. (2012). *Being and Time*. Oxford: Blackwell Publishing.

Hepburn, A., & Jackson, C. (2009). Rethinking subjectivity: A discursive psychological approach to cognition and emotion. In D. Fox, I. Prillentensky & S. Austin (Eds.). *Critical psychology: An introduction* (2nd ed.) (pp. 176–195). London: Sage.

Holzkamp, K. (1979). Zur kritisch-psychologischen Theorie der Subjektivität II: Das Verhältnis individueller Subjekte zu gesellschaftlichen Subjekten und die frühkindliche Genese der Subjektivität. *Forum Kritische Psychologie, 4*, 10–54.

Holzkamp, K (1991). Societal and life processes. In C. W. Tolman & W. Maiers (Eds.), *Critical psychology: Contributions to a historical science of the subject* (pp. 50– 65). Cambridge: Cambridge University Press

Holzkamp, K. (2013). Psychology: Social self-understanding on the reasons for action in the conduct of everyday life. In E. Schraube & U. Osterkamp (Eds.), *Psychology from the standpoint of the subject: Selected writings of Klaus Holzkamp* (pp. 233–241). London: Palgrave Macmillan.

Holzkamp, K. (2016) Conduct of everyday life as a basic concept of critical psychology. In E. Schraube & C. Højholt (Eds.), *Psychology and the conduct of everyday life* (pp. 65–98). London: Routledge.

Jørgensen, C. R. (2012). Deltagende observation i det psykoanalytiske rum. In M. Pedersen, J. Klitmøller & K. Nielsen (Eds.), *Deltagerobservation: En metode til undersøgelse af psykologiske fænomener* (pp. 91–107). Copenhagen: Hans Reitzels Forlag.

Juul Jensen, U. (2005). Sundhed, liv og filosofi. In U. Juul Jensen & P. Andersen (Eds.), *Sundhedsbegreber: filosofi og praksis* (2nd ed.) (pp. 9–41). Aarhus: Forlaget Philosophia.

Kant, I. (2004). *Critique of pure reason*. New York: Barnes & Noble.

Kristensen, K. A. (2008). *Hjemløshed og personlig livsførelse* (PhD dissertation). Copenhagen University: Department of Psychology.

Kristensen, K. A. (2013). At skabe rytmisk sammenhæng i tilværelsen. *Steinerskolen, 2013*(1), 48–53.

Kristensen, K. A., & Schraube, E. (2014). Conduct of everyday life. In T. Teo (Ed.), *Encyclopedia of Critical Psychology* (pp. 291–293). New York: Springer.

Kristensen, K.A., & Holm, J. (in preparation). *Co-creation in community health development: Collaborative research and learning in specialized institutions.*

Legrand, D. (2007). Pre-reflective consciousness: On being bodily in the world. *Janus Head, 9*(2), 493–519.

Lewin, K. (1936). *Principles of topological psychology*. London: McGraw-Hill.

Maturana, H. R., & Varela, F. J. (1980). *Autopoesis and cognition: The realization of the living*. Dordrecht: Reidel.

McQueen, D. V. (2007). Critical issues in theory for health promotion. In D. V. McQueen & I. Kickbush (Eds.), *Health & modernity: The role of theory in health promotion* (pp. 21–43). New York: Springer.

Merleau-Ponty, M. (1962). *The phenomenology of perception*. London: Routledge & Kegan Paul.

Munday, R. (n.d.). *Glossary of terms in Being and Time*. Retrieved from Http:/ www.visual-memory.co.uk/ b-resources/ b-glossary.html

Nordenfelt, L. (1987). *On the nature of health. An action theoretic approach*. Dordrecht: Reidel.

Nussbaum, M. (2009). *The therapy of desire: Theory and practice in Hellenistic ethics*. New Jersey: Princeton University Press.

Parker, I. (1997). Discursive psychology. In D. Fox, I. Prillentensky & S. Austin (Eds.). *Critical psychology: An introduction* (2nd ed.) (pp. 284–299). London: Sage.

Potvin, L., & McQueen, D. V. (2007). A reflexive discourse. In D. V. McQueen & I. Kickbush (Eds.), *Health & modernity: The role of theory in health promotion* (pp. 12–21). New York: Springer.

Sartre, J. P. (1991). *The transcendence of the ego: An existentialist theory of consciousness*. New York: Hill and Wang.

Schön, D. A. (1983). *The reflective practitioner*. New York: Basic Books.

Schütz, A., & Luckmann, T. (1973). *The structures of the life-world* (Vol. 1). Illinois: Northwestern University Press.

Schraube, E. (2013). First-Person perspective and sociomaterial decentering: Studying technology from the standpoint of the subject. *Subjectivity, 6*(1), 12–32.

Smithsonian Natural Museum (n.d.). *Homo erectus*. Retrieved from http://humanorigins.si.edu/evidence/human-fossils/species/homo-erectus

Teo, T. (2009). Philosophic concerns in critical psychology. In D. Fox, I. Prillentensky & S. Austin (Eds.). *Critical psychology: An introduction* (2nd ed.) (pp. 36–55). London: Sage.

Westen, D., & Gabbard, G. O. (1999). Psychoanalytic approaches to personality. In A. L. Pervin, & O. P. John (Eds.), *Handbook of Personality* (pp. 57–102). New York: The Guilford Press.

World Health Organization (1986). *The Ottawa charter for health promotion*. Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

Wojnar, D. M., & Swanson, K. M. (2007). Phenomenology: An exploration. *Journal of Holistic Nursing*, 25(3), 172–180.

Wood, B., & Richmond, B. G. (2000). Human evolution: taxonomy and paleobiology. *Journal of Anatomy, 197*(1), 19–60.

Zahavi, D. (2010) *Fænomenologi*. Frederiksberg: Roskilde Universitetsforlag

Zahavi, D. (2011) *Husserls fænomenologi* (2nd ed.). Frederiksberg: Samfundslitteratur

Acknowledgement

I wish to thank Niklas Alexander Chimirri, Ernst Schraube, and Bodil Pedersen for the many constructive and helpful comments for this article.

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